DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

HIGHLIGHTS
January 2010

CONGRESSIONAL TESTIMONY

Deputy Assistant Inspector General for Audits and Evaluations Testifies on Mental Health and Orthopedic Services at the VA Pacific Islands HCS

The Deputy Assistant Inspector General for Audits and Evaluations, Linda Halliday, testified at a Senate Veterans' Affairs Committee field hearing in Maui, HI, on mental health and orthopedic services for Veterans on the island of Maui. The Office of Inspector General (OIG) reported that although the VA Pacific Islands Health Care System (VAPIHCS) has experienced challenges in providing mental health services to Veterans on Maui and the other outlying islands, it is effectively using VA's Mental Health Initiative funding to recruit additional staff and expand telehealth services. OIG also reported that since fiscal year 2006, VAPIHCS has made significant strides in reducing wait times for elective orthopedic surgery procedures, most notably by hiring two orthopedic surgeons. Walter Stucky, Audit Manager, Seattle Office of Audits and Evaluations, accompanied Ms. Halliday at the hearing.

OIG REPORTS

Improvements Needed in Oversight, Storage, Mail, and Training at Roanoke, Virginia, VA Regional Office

The OIG Benefits Inspections Division conducted a review of the VA Regional Office (VARO) in Roanoke, VA, and determined that management faces challenges in providing benefits and services to Veterans, to include: addressing oversight of operational activities, acquiring adequate space to store Veterans' claims folders, associating claimant evidence with the Veterans' claims folders, and providing training to staff. The VARO management team needs to provide additional oversight and training of personnel responsible for processing claims identified as traumatic brain injury, herbicide exposure, and Haas cases. Additionally, management must improve controls over the safeguarding of Veterans' personally identifiable information, handling of claims-related mail, and responding to electronic inquiries. [Click for Report.]

Better Documentation and Assessment of Mental Health Risks Needed at Fayetteville, Arkansas, VAHCS

At the request of Representative Jo Ann Emerson, OIG reviewed the validity of allegations regarding the quality of mental health care provided to a patient at the Fayetteville, AR, VA Health Care System (HCS). OIG could not find evidence in the medical record documentation that the provider sufficiently explored relevant aspects of the patient's recent suicidal thoughts and/or further inquired about the location of the

patient's gun. Primary Care Service did not provide the patient with a mental health consult within the required timeframe and did not facilitate further assessment of the patient's mental health when he presented to a Community Based Outpatient Clinic for unscheduled visits with mental health issues. Although OIG identified these patient care issues, given all the facts in this case, including those relating to the care provided to this patient both at VA and at non-VA facilities, OIG cannot conclude that these deficiencies impacted the patient's outcome. OIG made recommendations to address the deficiencies found in this review. [Click for Report.]

Scanning Backlog, Nurse Staffing, and Communication Issues Found at Iron Mountain, Michigan, VAMC

At the request of the House Veterans' Affairs Committee Chairman, Bob Filner, OIG conducted a review to determine the validity of allegations regarding management decisions impacting patient care and work environment at the Oscar G. Johnson VAMC in Iron Mountain, MI. Three of the allegations resulted in OIG recommending that actions be taken to reduce the scanning backlog and establish a process to assure timely entry of significant information in patients' electronic medical records; managers initiate a review of registered nurse staffing to ensure coverage of the Emergency Department and Nursing Officer of the Day; and the Medical Center Director communicates, orally and in writing, organizational changes to all employees and that administrative supervisory lines are clearly written and effected in official personnel actions. [Click for Report.]

Telemetry Monitoring Problems Identified at VA Eastern Colorado HCS, Denver, Colorado

OIG performed a review of the VA Eastern Colorado HCS, Denver, CO, to determine the validity of allegations regarding inadequate telemetry heart monitoring practices and lack of staff training that related to two patient deaths. OIG did not substantiate the allegation that the deaths were a result of inadequate telemetry monitoring or lack of staff training. However, OIG substantiated that management had been informed of problems with the telemetry program prior to the patient deaths and had not identified a clear course of action or assigned responsibility to address concerns raised. OIG also substantiated the allegation that there were competency and training issues with medical support assistants and registered nurses assigned to telemetry. Managers concurred with OIG's recommendations to evaluate the telemetry program, require that all staff complete competency assessments and that training be provided as needed to maintain competency, and that there be clinical oversight of medical support assistants. [Click for Report.]

OIG Recommends Trending, Sharing of Infection Control Data at the Huntington, West Virginia, VA Medical Center

OIG conducted an inspection in response to allegations that a surgeon had poor infection control practices, a higher incidence of Methicillin Resistant Staphylococcus Aureus (MRSA), altered records to reflect lower blood loss for a procedure, and performed surgery on a patient who developed significant complications at the Huntington, WV, VA Medical Center (VAMC). OIG did not substantiate allegations

made against the surgeon, but did identify a lack of integration of infectious disease information between surgical services, the National Surgical Quality Improvement Program, Infection Control, and MRSA programs. OIG recommended that trended and analyzed infection control data be provided to key committee members and clinical managers. [Click for Report.]

Quality of Care Issues Reviewed at Clarksburg, West Virginia, VAMC
OIG reviewed the validity of allegations of poor patient care against the Louis A. Johnson VAMC in Clarksburg, WV. Although OIG did not substantiate all allegations, OIG concluded that there were deficiencies in the patient's care that warranted consideration of institutional disclosure to the family. Managers concurred with the recommendation to review the case with Regional Counsel to determine whether disclosure was managed appropriately. [Click for Report.]

Allegations of Coding and Billing Irregularities Not Substantiated Against Kansas City, Missouri, VAMC
OIG reviewed allegations regarding a pattern of inappropriate medical coding and billing to increase third party insurance reimbursements at the Kansas City, MO, VAMC. The allegation purported that the Medical Care Collection Fund Billing Department inappropriately added a Current Procedural Terminology "modifier 59," which indicates that a procedure or service was distinct or independent from other services performed on the same day, to the billing records for a patient receiving "Epoetin" injections. Approved claims including a modifier 59 will usually result in higher reimbursements. The complainant also alleged that the Billing Department inappropriately billed for complications attributable to the patient's participation in a voluntary research study. OIG was unable to substantiate the allegations and made no recommendations. [Click for Report.]

CRIMINAL INVESTIGATIONS
Former Executive Pleads Guilty to Conspiracy and Money Laundering
The former Chief Executive Officer (CEO) of a nursing home chain that received Federal funds pled guilty to conspiracy to commit wire fraud and money laundering. A multiagency investigation determined that the defendant conspired to create false invoices in order to obtain loans from lenders. The loans were intended for the improvement of the nursing home facilities but instead were used to pay for the CEO's personal expenses, including the purchase of a number of apartment complexes. As part of the plea agreement, the CEO agreed to forfeit $500,000 to the Government in the form of a lien placed on one of the complexes. In addition to the CEO, a former director of cash management, a nursing home administrator, and a regional accounts receivable manager were also previously convicted as a result of this investigation and are currently awaiting sentencing.

Deceased Veteran's Ex-Wife Sentenced for Misappropriation
The ex-wife of a deceased Veteran was sentenced to 3 years' incarceration, 3 years' probation, and ordered to pay restitution of $362,644 after pleading guilty to misappropriation by a fiduciary. A joint investigation conducted by OIG, the Federal

Bureau of Investigation, and the Defense Criminal Investigative Service revealed that at the time of the Veteran's death, he had named his minor son as the sole beneficiary for his military life insurance. The Veteran's ex-wife obtained court appointed guardianship over the life insurance funds, totaling approximately $450,000, in order for VA to pay the son. The investigation further determined that in less than 1 year, the defendant embezzled almost all of the funds, spending them on extravagant vacations, gambling, cars, and parties.

Three VA Greater Los Angeles HCS Employees Charged With Theft
Three Sepulveda, CA, VA employees were charged with grand theft after an OIG and VA Police investigation determined that the defendants fraudulently claimed overtime hours they did not work. The loss to VA is approximately $15,000.

Veteran Pleads Guilty to Identity Theft and Fraud
A Veteran pled guilty to a criminal information charging him with theft of Government property, aggravated identity theft, access device fraud, and bank fraud. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant, who had been dishonorably discharged from the military, assumed the identity of an honorably discharged Veteran and fraudulently received VA medical treatment, job placement in a VA work therapy program, and VA-supported temporary housing in a halfway house. The defendant also opened a credit card account using the honorably discharged Veteran's identity and subsequently committed approximately $20,000 in bank fraud before leaving Nashville, TN, and moving to Seattle, WA. The loss to VA is $23,574.

Daughter of Deceased Veteran Pleads Guilty to Theft of VA Benefits
The daughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA, forged her mother's signature on two VA Marital Questionnaire documents, and subsequently stole VA benefit funds direct deposited into her deceased mother's account. The loss to VA is $68,058.

Veteran Arrested for Making False Statements
A Veteran was arrested for making false statements after an OIG investigation revealed that he falsified his employment status on a VA Vocational Rehabilitation and Employment application and on other subsequent forms in order to receive VA benefits. The Veteran subsequently received approximately $11,000 for college tuition, supplies, subsistence allowance, and dependency pay over a 3-year period.

Defendant Pleads Guilty to Theft of Government Benefits
A defendant pled guilty to an indictment charging him with theft of Government funds and Stolen Valor. An OIG and U.S. Coast Guard Investigative Service investigation determined that the defendant obtained fraudulent DD-214s early in his 20-year career with the Navy and Coast Guard. The defendant represented himself as a Navy Seal who received multiple medals for valor for over 10 years while serving in the Coast Guard. Upon retirement, the defendant provided fraudulent DD-214s to VA when

applying for benefits claiming Post Traumatic Stress Disorder and lied extensively about combat exposure during mental health evaluations. The loss to VA is $13,923.

Birmingham, Alabama, VA Employee Arrested for Fraudulent Use of a Government Credit Card

A Birmingham, AL, VA employee was arrested following an indictment for fraudulent use of a credit card. An OIG investigation revealed that the defendant misused a Government-issued U.S. Bank travel card over a 3-month period, accruing approximately $3,400 in charges for personal expenses including vacations and vehicle loan payments.

Former Hines, Illinois, VA Employee Arrested for Sexual Assault

A former Hines, IL, VA employee was arrested and charged with two felony counts of sexual assault. During an OIG and local police investigation, the defendant admitted in a signed, sworn statement that he had inappropriate sexual contact with his 13 year-old daughter while she visited him at his VAMC onsite residence. The defendant subsequently resigned from his position with VA.

Veteran's Daughter Pleads Guilty to Elder Abuse

The daughter of a Veteran pled guilty to felony elder abuse. An OIG investigation determined that the defendant stole over $70,000 of her father's VA funds and spent them on alcohol and other personal items. The defendant never informed her father that he had received a $70,000 retroactive VA benefit award check.

Son of Deceased Beneficiary Pleads Guilty to Theft of VA Benefits

The son of a deceased VA beneficiary pled guilty to an indictment charging him with theft of public money. An OIG investigation revealed that the defendant submitted false financial status reports to VA, resulting in the continuation of benefits to his deceased mother. The defendant subsequently stole the VA funds that were direct deposited to his mother's account after her death in April 1987. The loss to VA is approximately $204,000.

Common-Law Wife Pleads Guilty to Theft of VA Benefits

The common-law wife of a deceased Veteran pled guilty to theft of Government funds. An OIG investigation determined that the defendant failed to report her remarriage to VA and continued to fraudulently receive Dependency and Indemnity Compensation benefits. The loss to VA is $73,064.

Houston, Texas, VAMC Employee Arrested on Fugitive Warrant

A Houston, TX, VAMC employee, who is also a Veteran, was arrested at the medical center with the assistance of the OIG for violating the terms of his probation following a 1999 homicide conviction. The employee's criminal history includes prior arrests for manslaughter, fraud, controlled substances, and carrying prohibited weapons.

(original signed by:)
GEORGE J. OPFER
Inspector General